COMPLAINTS ABOUT HEALTH INFORMATION DISCLOSURES

Mail To: Privacy Officer, Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203
*** Please include copy of your Medicaid ID card and Driver's License, or equivalents ***

The Health Insurance Portability and Accountability Act of 1996 requires that we protect the privacy of your protected health information. You have a right to complain, in writing, about situations in which you believe we, or other organizations that work for us, have not met our responsibility to safeguard your protected health information. The Colorado Department of Health Care Policy and Financing cannot take away your benefits or retaliate against you in any way because of this complaint. Please give us as much detail as you can so we can investigate this event and make sure we improve the way we protect the health information of all of our clients. The Department is not required to respond to or take action on every complaint. See the Department's Privacy Policy and Procedures on *Right to File Complaint,* pursuant to 45 C.F.R. 164.530 (d).

Date: _____

Name: _____

State ID number: _____ Signature: _____

Date of birth: _____ Social Security # : _____

Address: _____

City, State, Zip: _____ Phone: _____

Name of Designated Personal Representative: _____
*** Legal documentation must be included to show authority to receive information ***

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____

DETAILS OF COMPLAINT (Please be as specific as possible with dates, times, and any specific policy, procedure, or action taken; include names and documentation, if any, of anyone at the Department of Health Care Policy and Financing with whom you have talked to about this.)

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You may also file a Complaint with the Secretary of United States Health and Human Services by writing:

Secretary of U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

FOR INTERNAL USE ONLY

Date received: _____ Date reviewed: _____

Reviewed by: _____ Title: _____

Reviewer's comments and actions: _____